

Participant Authorization for the Deduction of Healthcare Premiums

IMPORTANT LEGAL NOTICE

The Municipal Employees' Annuity and Benefit Fund of Chicago (the "Fund") is proceeding with allowing for a monthly healthcare insurance premium deduction (the "Deduction") from an annuitant's net monthly annuity benefit (the "Annuity") to the healthcare insurance plan provider ("Provider") stated below. The Deduction is pursuant to the statutory authority under Section 8-244(b) (1) of the Illinois Pension Code, with the understanding that this action might require revisions and adjustments. The Fund takes no position with respect to annuitant health care options and does not endorse or sponsor any particular healthcare insurance carrier or healthcare insurance coverage. In processing the Deduction, the Fund is solely performing an administrative function and is only responsible for the Deduction of premiums requested by your Provider. Any dispute regarding the Deduction amount is solely between the annuitant and the Provider.

A completed and signed form does not guarantee that the Fund will process the Deduction from the Annuity. The Provider must comply with all Fund requirements to process any Deduction from an Annuity. The annuitant is responsible for making premium payments to their Provider until the Fund receives and processes the completed and signed form. The Fund will continue to make the Deduction until written notification of cancellation is received. If an annuitant's Deduction exceeds his/her Annuity, the Fund cannot make any Deduction on their behalf.

WAIVER OF CLAIMS AND AUTHORIZATION

Pursuant to Section 8-244(b) (1) of the Illinois Pension Code, I hereby authorize and direct the Fund to make a Deduction for my monthly healthcare premium. I understand that the Deduction will be taken from my net monthly annuity benefit.

Member Name (First, Middle Initial and Last): _____

Last 4 digits of Social Security Number: _____

Persons Insured (if other than Member): _____ Last 4 digits SS#: _____

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Persons Insured (if other than Member): _____ Last 4 digits SS#: _____

Persons Insured (if other than Member): _____ Last 4 digits SS#: _____

Phone Number: _____

Provider Information:

Provider Name: AETNA Plan Name: _____

As a condition of authorizing this Deduction, I accept all responsibility for truth and accuracy of all information I have provided. I hereby release the Fund, its staff, its officers, its Board of Trustees, and any of its advisors from any liability arising from the administration of the Deduction out of my Annuity. By signing this form, I agree that I will not make any legal claim of any kind against the Fund, its staff, officers, its Board of Trustees, and any of its advisors. Should my authorization result in any liability to me, including interest, penalties or tax, I understand that my ability to participate in this program is a valuable benefit for which I am willing to sign this Waiver of All Claims.

I have read and understand the information contained on this form and its instructions and agree to all the conditions for this authorization, including the Waiver of All Claims against the Fund, its staff, its officers, its Board of Trustees, and any of its advisors.

Annuitant Signature _____ Date _____

Spouse Signature (If Applicable) _____

**** THIS LINE MUST BE FULLY EXECUTED AND SIGNED ****